BHSF Waiver
Rev. 01/01
Prior Issues Usable
IV

Medicaid Program
Waiver of Confidentiality

All information gathered on an individual is personal and confidential. The following is written permission to release the information requested below.

I understand that the information in the record of:

Name _____ SSN _____ Case ID # _____

Address _____

Is personal and confidential. However, I give my permission for:

Name _____

Address _____

to release to:

☐ Louisiana's **Medicaid Program** **OR** ☐ Name: _____

Address: _____

City/State/Zip: _____

☐ the information requested on attachment for the specific purpose of: **OR** ☐ Other: _____

_____

☐ determining Medicaid eligibility **OR** ☐ Other: _____

_____

I understand that my permission to release this information may be canceled by me in writing at any time except when the information has already been released.

_____ _____
Signature of Applicant/Recipient (Including Minor) Date

The undersigned certifies that he/she is the parent/guardian/custodian/authorized representative of the applicant/recipient listed above and has the legal authorization to sign on behalf of the applicant/recipient by operation of law.

_____ _____
Signature of Authorized Representative Date

_____ _____
Signature of Witness Date

_____ _____
Signature of Witness Date